Client's label when possible

Making the Links: Referral Form

Full Name:	Tel:	Can we leave a voice message? ☐ YES ☐ NO
Date of birth:	Email:	
Date of referral:	Reason for referral:	Referral made by:

Risk Assessment:
Harm to self? ☐ YES ☐ NO
Harm to others? ☐ YES ☐ NO
If yes, safety plan created ☐ YES ☐ NO

Previous history accessing mental health services:
☐ YES ☐ NO
Agency/Practitioner:

Presenting Issues

☐ Aging
☐ Anger Management
☐ Anxiety/Stress
☐ Body Image Issues
☐ Depression/Sadness
☐ Grief/Loss
☐ Guilt/Shame
☐ Eating Difficulties
☐ Loneliness/Social Isolation
☐ Self-esteem
☐ Suicidal Thoughts
☐ Substance Misuse
☐ History of Trauma

☐ Childhood Abuse
☐ Family Issues
☐ Partner Abuse/Violence
☐ Relationship Issues
☐ Sexual Assault/Abuse
☐ STIs 101
☐ App/Social Media Compulsion
☐ Barebacking/Condomless Sex
☐ HIV Anxiety
☐ Negotiating Safer Sex
☐ PrEP Referral
☐ Sexual Compulsion
☐ Sexual Difficulties

☐ Ableism
☐ Coming Out Issues
☐ Gender Identity Issues
☐ Homophobia
☐ Racism
☐ Stigma/Discrimination
☐ Transphobia
☐ Immigration/Settlement Issues
☐ Drug Coverage
☐ Education Issues
☐ Employment Issues
☐ Housing Issues
☐ Socioeconomic Concerns

☐ Other: ____________________________

Community Referrals

Date	Organization/Program	Follow Up	Notes
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	

Resources/Materials Disseminated

Date	

Progress Notes

Date	